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A 000	INITIAL COMMENTS	A 000		

An unannounced, on-site complaint investigation was conducted on September 04-07, 2007. The investigation resulted in an Immediate Jeopardy (IJ) identification on September 07, 2007 at 1435. The immediate jeopardy was not abated and was determined to be ongoing as evidenced by the following:

1. Open medical record review of Patient #20 revealed a 30 year old male involuntarily admitted on 04-01-2007 for schizophrenia, paranoid type. On 4-12-2007 a facility recreational therapist (RT) arrived at the Unit 2, 3 East at approximately 1900 and asked a Health Care Technician (HCT) who could go out for an activity. Interview with the RT revealed "the staff didn't tell me anything about (Patient #20) when I went up there". The interview revealed that Patient #20 "got in line to go out along with 5 other people". The interview further revealed the group was escorted to the therapeutic center to shoot pool. Patient #20 requested to go out to smoke. The RT went with him and stayed approximately 1 minute then went back inside, out of view of Patient #20, to check on the other patients. About 30 seconds later (around 1935), the RT looked back outside and Patient #20 was missing. The patient was found on 04/12/2007 at 2055 and had sustained some physical injuries and abrasions which were treated by the facility's Physician Assistant.

Interview with Registered Nurse (RN) #1 during the survey revealed the nurse was the charge nurse for Unit 2, 3 East the day Patient #20 eloped. The interview revealed "I was not asked by (Recreation Therapy Technician #1) if (Patient #20) could go out. I would not have approved (Patient #20)". The interview revealed that

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Patient#20 had threatened to leave the day before he eloped. The interview further revealed "the nurse should make the decision about whether patients go out". The interview further revealed "the rec (recreational) therapists were asking the Health Care Techs (technicians), not the nurse". The interview further revealed "the charge nurse is ultimately responsible for all patients whereabouts, not the techs".

Interview with the Recreation Therapy Supervisor during the survey revealed there is not a uniform procedure for the recreation therapy technicians to use throughout the facility. The interview revealed the therapy technicians use a patient list that they originate with a list of patients they are taking out from the U-2 building. When taking patients out of other units and wards (other than U-2) they use a patient sign in/sign out list that is kept on the wards. The interview revealed "the therapeutic recreation department does not have a policy or procedure for taking patients off the units". The interview further revealed the facility has been "working on a new policy for several months".

Investigation revealed the hospital's leadership was made aware of the elopement shortly after the patient was found missing. Investigation revealed the patient was identified by the supervising nurse as at risk to elope as well as a safety risk to self and others. Investigation by the facility revealed there were issues identified with the patient elopement to include nursing supervision and patient accountability while off the unit. Investigation revealed the facility's leadership failed to ensure patient safety by failing to have a hospital-wide process in place to supervise and monitor patients with a known risk

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A 000	Continued From page 2	A 000		

to elope and are considered a danger to self and others, resulting in an elopement.

2. Closed medical record review revealed patient #6, a 45 year old male, was admitted on 01/23/2007 with diagnoses of paranoid schizophrenia, cocaine abuse and hypertension. On 01/28/2007 at 0850 the patient was found slumped in chair, pale and unresponsive with vital signs: Blood Pressure 90/52 (lower than normal), Pulse 48 (lower than normal), Respirations 30 (faster than normal). A Code Blue was called and the physician's assistant responded at 0852 and ordered oxygen. Interview during the survey revealed oxygen was not applied to the patient until emergency medical services arrived at 0910 (20 minutes after the patient was found unresponsive). Record review revealed patient #6 was transferred to an acute hospital with hypotension and sinus bradycardia (slow heart rate) and had a pacemaker (to regulate the heart rate) placed in the acute hospital.

Investigation revealed the facility continues to have issues with response to medical emergencies as well as Code Blue documentation through interview and review of Performance Improvement documentation. Investigation revealed the facility's leadership failed to ensure patient safety by failing to have a hospital-wide process in place for immediate monitoring and intervention in the event of a serious medical emergency.

The findings of scenerios #1 and #2 were discussed with administrative staff on September 07, 2007 at 1435. The investigation resulted in an immediate jeopardy to patient's health and safety beginning on 1-28-2007 at 0850. The

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A 000	Continued From page 3 immediate jeopardy was not abated. A summary of immediate action taken by the hospital submitted 9-07-2007 included: New policy "Accounting for Patients Off-Ward" with attached "Off-Ward Accountability List" authored "To establish guidelines regarding accountability of patients who are being escorted by staff to a location other than their assigned ward." Revision of policy "Emergencies, Medical patients/Code Blue Procedures", Medical Emergencies" section to clarify immediate nursing interventions for medical emergencies (currently approved by medical staff),as well as documentation requirements. A "read and sign" memorandum directive for nursing staff and facility police officers effective on 9-07-2007 as staff arrive for duty addressing: - review of new policy "Accounting for Patients Off Ward" with inservice on the new Off-Ward Accountability List - an on-site Registered Nurse (RN) will be contacted by the admission office staff to assess all patients upon arrival in the admissions office and will screen patient's for any medical emergency present, - review of revised "Medical Emergencies" policy; and, - nursing documentation expectations for any medical emergency care rendered. Responsible party - Interim Director of Nursing with a target date of completion 9-17-2007. Monitoring for above will be completed by the Performance Improvement Department for 100% completion of the read and sign by all staff	A 000		

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A 000	Continued From page 4 required to review. Monitoring of 25 observations per week of staff compliance with the "Accounting for Patient's off Ward" policy and "Accountability List" by the PI Department will also be conducted for 100% compliance. Monitroing by the PI Department will be conducted for compliance with "Medical Emergencies" record audit of the "Code Blue" documentation for 100% compliance (the Code Blue report is required to be completed with any medical emergency).	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on review of the facility's policies and procedures, review of open and closed medical records, staff and physician interviews and observations during tour, the hospital's governing body failed to ensure systems were in place to provide for a safe environment by failing to ensure supervision of a patient at risk to elope and under a court order for an involuntary commitment resulting in an elopement for 1 of 6 patients reviewed who attempted to escape/elope (#20). The facility's governing body failed to provide an organized nursing service by failing to ensure appropriate emergency measures were provided to 2 of 2 unresponsive patients during a medical emergency. (#6, #9). The hospital's governing body failed to ensure systems were in place to ensure the least restrictive restraint	A 043		9/20/07

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method was utilized to restrain 1 of 3 restrained patients (#10). The facility's governing body failed to ensure medical staff accountability and oversight for the quality of care provided to restraint patients by failing to ensure the least restrictive restraint method was ordered to restrain 1 of 3 restrained patients (#10).

Findings include:

A) The hospital's governing body failed to ensure systems were in place to provide for a safe environment and ensure supervision of a patient with a risk to elope and under a court order for an involuntary commitment resulting in an elopement for 1 of 6 patients reviewed who attempted to escape/elope (#20);

~ cross refer to 482.13 (c) (2) Patient Rights: Care in a safe setting Tag A0144

B) The facility's governing body failed to provide an organized nursing service by failing to ensure appropriate emergency measures were provided to 2 of 2 unresponsive patients during a medical emergency. (#6, #9)

~ cross refer to 482.23 (b) (3) RN Supervision of Nursing Care Tag A0395

C) The hospital's governing body failed to ensure systems were in place to ensure the least restrictive restraint method was utilized to restrain 1 of 3 restrained patients (#10),

~ cross refer to 482.13 (c) (2) Patient Rights: Restraint or seclusion Tag A0165

D) The facility's governing body failed to ensure

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A 043	Continued From page 6 medical staff accountability and oversight for the quality of care provided to restraint patients by failing to ensure the least restrictive restraint method was ordered to restrain 1 of 3 restrained patients (#10). ~ cross refer to 482.22 (b) Medical Staff Accountability Tag A0347	A 043		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on review of the facility's policies and procedures, review of open and closed medical records, staff and physician interviews and observations, the facility staff failed to protect the rights of patients by failing to: A) ensure observation of a patient with a risk to elope and under a court order for an involuntary commitment resulting in an elopement for 1 of 6 patients reviewed who attempted to escape/elope (#20); B) ensure the least restrictive restraint method was utilized to restrain 1 of 3 restrained patients (#10), C) ensure that staff wear personal body alarms for patient and staff safety per the facility's policy; and, D) ensure the psychiatric medical unit environment was free of safety hazards. Findings include: A) The facility staff failed to ensure observation of a patient under a court order for an involuntary	A 115		9/20/07

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A 115	Continued From page 7 commitment resulting in elopement for 1 of 6 patients reviewed who attempted to escape/elope (#20); ~ cross refer to 482.13 (c) (2) Patient Rights: Care in a safe setting Tag A0144 B) The facility staff failed to ensure the least restrictive restraint method was utilized to restrain 1 of 3 restrained patients (#10), ~ cross refer to 482.13 (c) (2) Patient Rights: Restraint or seclusion Tag A0165 C) The facility leadership staff failed to ensure that staff wear personal body alarms for patient and staff safety per the facility's policy; ~ cross refer to 482.13 (c) (2) Patient Rights: Care in a safe setting Tag A0144 D) The facility staff failed to ensure the psychiatric medical unit environment was free of safety hazards. ~ cross refer to 482.13 (e) (3) Patient Rights: Care in a safe setting Tag A0144	A 115		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on review of the facility's policies and	A 144		9/20/07

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procedures, review of open and closed medical records, staff and physician interviews and observations, the facility failed to: provide care in a safe setting by A) failing to ensure observation of a patient with a risk to elope and under a court order for an involuntary commitment resulting in an elopement for 1 of 6 patients reviewed who attempted to escape/elope (#20); B) failing to ensure that staff wear personal body alarms for patient and staff safety per the facility's policy; and, C) ensure the psychiatric medical unit environment was free of safety hazards.

The findings include:

A) failing to ensure observation of a patient under a court order for an involuntary commitment resulting in elopement for 1 of 22 patients reviewed (#20).

Review of the facility's current policy, VI-S-2a, "Precautions and Standard Accountability", revealed "The goal of XX Hospital is to provide quality individualized inpatient psychiatric services in the most effective and safest manner possible. During the provision of all care, XX Hospital staff takes every precautionary measure to ensure the safety of patients as clinically indicated. All patients are regularly monitored with regards to safety and location. Those patients requiring additional safeguards to ensure safety are placed on precautions". The policy further revealed patients that are identified as "Escape Precautions" is identified with a "red E.P." (escape precautions) on the Patient Accountability Sheet.

Review of the facility's current policy, VI-P-8, "Management of Privileges and Passes -

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Granting Off-Unit....Passes",revealed "Granting of passes shall be based on the individual client's legal and clinical status. ... Treatment teams are responsible for determining the client's status, including the ability to function safely in a environment less structured than the unit setting... ".

Review of the facility's current policy, VI-P-1a, "Patient Accountability", revealed "All clinical staff members have responsibility in the maintenance of patient accountability. This includes (but is not limited to) Nursing Services, Psychology, Medical Staff, Clinical Dieticians, Rehab (rehabilitation) Services, Social Work, and Unit Directors. ... Staff members taking the patients or conducting activities off ward/unit based treatment malls are responsible for maintaining supervision and accountability".

Review of the facility's current nursing policy, #V(E-3), "Escorting Patients" revealed "Nursing Service shall be required to escort patients to a variety of functions and shall provide that service in a safe and secure manner. Upon leaving the unit with a group of patients, a list of patients shall be left with the charge person and a list taken with the technician who is to accompany the patient. The patients shall be accounted for when leaving the unit, reaching the activity, leaving activity and upon return to the unit/ward. ...Nursing staff shall review patients scheduled for activities and if discomfort is felt regarding any patient listed, that concern should be discussed with the nurse or physician".

Review of an open medical record revealed Patient #20, a 30 year old male involuntarily admitted on 04/01/2007. Review of the

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physician's admission history and physical dated 04/01/2007 revealed "this is a rapid readmission....patient believes that someone is out to kill him. He threatened to kill his family and everybody". The admission history revealed the physician's diagnostic impression documented as "schizophrenia, paranoid type". Review of the Biopsychosocial History and Assessment completed by the social worker on 04/03/2007 revealed that patient has "dangerous behavior toward self/others" and "has serious difficulty in impulse control (exhibited assaultiveness, suicidal behavior...) and "pt (patient) is psychotic, uncooperative and impulsive". Review of the facility's document "Precaution Flowsheet", revealed Patient #21 was on every 15 minute checks on 04/11/2007. Review of the progress notes dated 04/11/2007 at 1430 documented by a social worker revealed "pt was seen today for staffing. The more he talked the more delusional he sounded". Review of the progress notes dated 04/11/2007 at 1630 documented by Nurse #1 revealed "patient clearly delusional. Threatening to beat M.D. (physician). ... Pt unable to be redirected. Pt tried to come in office to approach M.D. Given Haldol (anti-psychotic drug) 10 mg (milligrams) IM (intramuscular) and Ativan (sedative) 2 mg IM". Review of the progress notes dated 04/12/2007 at 1100 documented by a psychiatrist revealed "met w/ (with) pt re: (regarding) court. Attended court with pt. Pt presented paranoid and expressed delusional. He was not happy w/ outcome. Follow w/ pt re: long term treatment...". Review of the progress notes dated 04/12/2007 at 2000 by a physician revealed "pt. reportedly escaped from therapeutic center and reportedly was telling staff that he was worried about his children. Pt reportedly paranoid and delusional. Pick up order issued". Progress

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notes dated 04/12/2007 at 2145 documented by Nurse #1 revealed "At 745 pm received call from (Recreation Therapy Technician #1) that this patient had escaped from group. Supervisor immediately called and Team E Code S called. According to recreation therapy pt noted to be missing at 735 pm. Dr called at 755 pm for orders. Order received for pick up....". Documentation by Nurse #1 on 04/12/2007 at 2050 revealed "patient sister notified that patient had been found". Documentation by Nurse #1 on 04/12/2007 at 2055 revealed "Dr notified. Patient found and that patient has sustained some physical injuries, abrasions and PA (physician's assistant) has been called to see patient. Pt placed on escape precautions". Review of the progress notes dated 04/12/2007 at 2120 documented by Recreation Therapy Technician #1 revealed "pt. was taken to the therapeutic center with other peers. He was checked on at 7:30 p.m. Pt was smoking a cigarette on the porch of the therapeutic center. Pt. was discovered missing around 7:35 p.m. Nurse on ward was notified at 7:45 p.m.".

Interview with Recreational Therapy Technician #1 on 09/07/2007 at 0930 via telephone revealed the technician was working 04/12/2007. The interview revealed she went over to Unit 2, 3 East "around 1900" on 04/12/2007 and asked "who can go out". The technician revealed there was no list of patients and their approved activities on the unit so she asked the Health Care Technician who could go out. The interview revealed "the staff didn't tell me anything about (Patient #20) when I went up there". The interview revealed that Patient #20 "got in line to go out along with 5 other people". The interview further revealed the group was escorted to the therapeutic center to

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shoot pool. The technician stated "we shot pool for 30 minutes. Then (Patient #20) told me he was going out to smoke. I went with him and stayed approximately 1 minute. I went back inside to check on my other patients. About 30 seconds later, I looked and he was gone". The interview revealed the technician could not see Patient #20 from inside stating, "he was on the porch when I left him". The interview revealed "I was a temporary at the time and didn't know (Patient #20's) history. If I had known his history or how he was the day before, I would not have taken him out". The interview further revealed "I now have a list of patients that I'm taking out. I have the nurse sign it before I leave the unit". The interview further revealed "Now, someone must watch patients outside at the treatment center at all times. I take full responsibility for his disappearance. I took him out and I should have watched him".

Interview with Registered Nurse (RN) #1 on 09/07/2007 revealed the nurse was the charge nurse for Unit 2, 3 East the day Patient #20 eloped. The interview revealed "I was not asked by (Recreation Therapy Technician #1) if (Patient #20) could go out. I would not have approved (Patient #20)". The interview revealed that Patient#20 had threatened to leave the day before he eloped. The interview further revealed "the nurse should make the decision about whether patients go out". The interview further revealed "the rec (recreational) therapists were asking the Health Care Techs (technicians), not the nurse". The interview further revealed "the charge nurse is ultimately responsible for all patients whereabouts, not the techs".

Interview with a health care technician on

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A 144	Continued From page 13 09/07/2007 at 1130 revealed the technician has worked on Unit 2, 3 East since 03/2007. The interview revealed the lead health care technician is responsible for letting the recreation therapy technicians know which patients can leave the unit and go to the recreation center. The interview revealed, "I have signed the sheet before saying patients could leave the unit". Interview with the Recreation Therapy Supervisor on 09/07/2007 at 1030 revealed there is not a uniform procedure for the recreation therapy technicians to use throughout the facility. The interview revealed the therapy technicians use a patient list that they originate with a list of patients they are taking out from the U-2 building. When taking patients out of other units and wards (other than U-2) they use a patient sign in/sign out list that is kept on the wards. The interview revealed "the therapeutic recreation department does not have a policy or procedure for taking patients off the units". The interview further revealed the facility has been "working on a new policy for several months". Interview with the patient's physician (Physician A) on 09/07/2007 at 1300 confirmed "(Patient #20) was an escape risk. He should not have been allowed to go out to the recreation center that day (04/12/2007) because he was psychotic and uncooperative". B) failing to ensure that staff wear personal body alarms for patient and staff safety per the facility's policy Review of the current facility policy, "Personal Body Alarm", "the hospital provides a body alarm transmitter to designated staff in designated	A 144		

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buildings who are principally assigned to intervene or assist in an emergency incident associated with patient care or who may be isolated and need assistance for the care of a patient". The policy further revealed the following procedure: "...2. Pagers are assigned each shift to designated nursing staff. These pagers are accounted for and assigned each shift by the RN (registered nurse) in charge or other designated nursing staff...12. Employees shall wear transmitters/pagers at all times while on duty in patient areas...14. Employees assigned a body alarm transmitter shall test in once weekly."

Interview with a registered nurse on 09/04/2007 at 1440 revealed she is the charge nurse for Unit 2, 3 East, a male adult, acute psychiatric unit. The interview revealed that all health care technicians and nurses are supposed to wear body alarms. The nurse stated "I lost my body alarm over a year ago and I'm not going to pay $300 to replace it". The nurse revealed the policy was not followed nor enforced.

Interview with a health care technician on 09/04/2007 at 1410 revealed he is assigned to Unit 2, 3 East, a male adult, acute psychiatric unit. The technician revealed "I would try to redirect the patient before using physical restraint" He stated, "I would wrap him up and then use my panic button". The technician was asked to show the surveyor his panic button then stated, "I don't have it with me so I'd have to call for help". The interview further revealed "I don't know where it is. It might be in my locker". The health care technician revealed "I think I'm supposed to wear it".

Interview with the interim director of nursing on

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A 144	Continued From page 15 09/06/2007 at 1050 revealed the alarm system has been in place for 3-5 years. He stated "each staff member is assigned a body alarm. We have a shortage of them right now. We have a few loaners in the nursing office but not enough for everyone . The interview confirmed the policy states that all employees in patient care areas should wear a personal body alarm. C) ensure the psychiatric medical unit environment was free of safety hazards Observation upon entry of the psychiatric medical unit on 09/04/2007 at 1500 revealed patient #15 walking down the hall, yelling and screaming at staff. Further observation revealed patient #15 sitting in a chair in patient room 202. Observation of room 202 revealed two empty intravenous (IV) bags hanging on an intravenous pole with an electrical pump and attached cord (4-6 feet long). Observation revealed intravenous tubing approximately six feet in length was attached to the IV bags. Further observation revealed a patient room (room 201) across the hall with a closed unlocked door. Observation of the contents of room 201 revealed a C-pap machine (to assist with breathing). Observation revealed a nasal cannula (used to supply oxygen to the nose) with tubing attached (tubing was approximately six feet in length). Further observation revealed an oxygen compressor with nasal cannula tubing attached (approximately six feet in length). Observation revealed an unlabelled gallon size opaque plastic container filled with clear fluid sitting on the floor. Observation revealed the community bathroom door was unlocked. Further observation revealed signage on the door that stated "Keep locked at all times".	A 144		

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A 144	Continued From page 16 Record review of patient sitting in room 202 revealed patient #15 was admitted on 05/10/2007 with the diagnoses of dementia and schizoaffective disorder bipolar type. Record review revealed patient #15 was on 15 minute checks for safety due to increased psychoses. Record review revealed patient #15 was on constant awareness precaution around the clock for his psychosis....auditory and paranoid delusions (patient was alone in room 202 without supervision). Interview on 09/04/2007 at 1540 with the nurse manager revealed "IV poles and tubing have been in the room since the 0800 administration time". Further review revealed the equipment should have been removed after administration of the medication as they are a safety risk. Interview revealed all patient room doors and the community bathroom door should be locked when not in use to prevent patients wandering into the rooms and for patient safety.	A 144		
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review and staff interview, the facility's staff failed	A 165		9/20/07

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to ensure the least restrictive restraint method was utilized to restrain 1 of 3 restrained patients (#10).

Findings include:

Review of facility policy "Restrictive Interventions" effective 11-01-06 revealed "Policy:...physical restraint...shall be limited to emergencies where there is an imminent risk of a patient physically harming self or others. No restrictive intervention shall be used unless less restrictive interventions have failed..." Further review of policy revealed "Types of Restrictive Interventions:...Physical Restraint...Only professionally manufactured, hospital-approved devices may be used according to the manufacturer's instructions and for the purpose intended." Review of policy revealed "Procedures: Restraint Devices: 1. All (name of facility) staff shall use only approved restraint products...4. Law Enforcement may only use handcuffs on campus for non-therapeutic official law enforcement interventions."

Closed record review for patient #10 revealed a 29 year old male presented to the psychiatric facility on 8-02-2007 at 2200 for evaluation and treatment of alcohol dependence. Review of nursing documentation on the "Restrictive Interventions Progress Note" (RIPN) revealed "Pt (patient) received to unit at 1155pm 8-02-07 after receiving 2mg (milligrams) Ativan (anti-anxiety medication) IM (intramuscular) @ 1122pm in Admissions Department...Pt acutely disorganized...at 0110 pt remained agitated, combative, disoriented - (physician's name) contacted for Ativan to treat acute withdrawal symptoms. Pt required 4 staff to observe & keep from running around (with) unsteady gait. Pt

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struck at staff members - placed in NCI (non-crisis intervention) hold & transported to restraints at 0129." Review of nursing documentation on the RIPN revealed Ativan 2mg po (oral) given at 0110. Further review of documentation on the RIPN at 0145 revealed "Release of patient from restrictive intervention:...Patient released from restrictive intervention(s) at Date: 8-03-07 Time: 0145...Other (describe) Released for transfer to (acute medical facility name)..." Review of nursing progress notes at 0215 revealed "...Client handcuffed per EMS request for transport...Discussed with (administrative nurse) at RNO (Administrative nursing office). Order obtained per (physician's name) as client combative and EMS uncomfortable (with) unrestrained transport..." Review of physician's orders on 8-03-2007 at 0200 revealed a telephone order received by a facility Registered Nurse "Handcuffs for xport (transport) to (acute medical facility's name) via EMS"

Review of facility Police Department Case Report on 8-03-2007 at 0150 revealed "On Friday morning at 0150 I, (officer's name), met (name of EMS company) at the traffic light...When we arrived on the ward, we found the patient that was to be transported was in leather restraints. The staff on the ward stated that the patient was combative. The EMT in charge stated that the patient would have to be restrained in the ambulance or they would not transport the patient to the hospital. The EMS and (hospital name) staff expected me to place metal handcuffs on the patient so that he could be transported. I did not see or hear anything that would justify placing handcuffs on the patient. He was not violent or combative nor was any emergency situation that I

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felt like it was warranted. I informed RN (administrative nurse supervisor's name) that I could not handcuff a patient without just cause, but if the doctor on duty made the order for metal handcuffs, then it could be done according to hospital policy. The unit nurse in charge called (physician's name) and he did give the order for the patient to be handcuffed while being transported in the ambulance. I placed the handcuffs on the patient and gave the nurse, who was going with the patient to the hospital, the key and instructed her to remove the cuffs when they arrived at the hospital and to return the cuffs to me when transportation picked her up and brought her back to (hospital's name)."

Interview with the reporting police officer on 9-06-2007 at 0958 revealed when he arrived on the unit the patient was in 4-point leather restraints. Interview further confirmed the statement in the report that the patient was not combative when the officer arrived on the unit. Interview confirmed the officer had no cause for placing the patient in handcuffs for law enforcement purposes. Interview confirmed the EMS made the demand for the continued restraints for transport to the medical facility or they would not transport the patient. Interview revealed there were no other alternatives available to restrain the patient other than the metal handcuffs. Interview revealed there was an attempt to remove the leather restraints from the bed, but the restraints were attached to the bedframe. Interview revealed once the unit nurse received the verbal order the officer placed the handcuffs on the patient. Interview revealed the patient was cooperative while placing the handcuffs. Interview further revealed the patient verbalized understanding of the procedure when

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explained to the patient by the officer. Interview revealed he was the only officer on campus at the time and for safety reasons could not leave the campus. Interview revealed the officer gave the handcuff key to the nurse after a brief inservice on how to unlock the handcuffs once the patient arrived at the medical facility. Interview revealed the officer had received at least eight hours of training on the use of handcuffs in officer training. Interview revealed such injuries as radial nerve and blood vessel injury, loss of circulation to the hand, swelling of the wrist and skin tears or lacerations can easily occur if the pressure exerted by the handcuff on the wrist is not monitored. Interview further revealed the officer did not contact his supervisor prior to using the handcuffs as a non-law enforcement restraint device.

Interview with the physician ordering the handcuffs as a restraint on 9-06-2007 at 0930 revealed only psychiatry staff can order restraints. Interview revealed that the metal handcuffs was the only device available to transport the patient with restraints. Interview revealed the physician was aware the decision to restrain the patient was a demand of the emergency medical transport staff. Interview revealed the physician is not aware of any policy on how to handle a situation where a patient needs to be transported by restraints. Interview revealed the decision was made that the metal handcuffs with monitoring by facility nursing staff during the transport by EMS was the least restrictive method available.

Interview with nursing administrative staff on 9-06-2007 at 1050 revealed handcuff use is for criminal justice use only and not indicated for clinical use. Interview revealed there was a brief

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meeting "a few weeks ago" regarding the patient being placed in metal handcuffs. Interview further revealed the action from the meeting was a change in policy to further emphasize that metal handcuffs can not be utilized as a restraint device in the clinical setting. Interview revealed nursing training has been put into place as of last week to educate nursing that handcuffs can not be utilized as a restraint device in the clinical setting. Interview failed to reveal other alternatives to guide the nursing staff as to how to handle a patient requiring transport in restraints. Interview confirmed the nursing staff did not follow facility policy on not using metal handcuffs as a restraint device.

Interview with the facility Clinical Director (administrative liason physician) on 9-06-2007 at 1500 revealed there was a brief meeting about three weeks ago regarding the use of handcuffs as a restraint. Interview revealed there were no minutes from the meeting and no specific date could be recalled. Interview revealed the decision was made to further detail in the current policy (effective 11-01-06) that handcuffs could not be utilized as a restraint device. Interview revealed the physician did not know of any other least restrictive alternatives other than chemical restraint or a manual hold by staff during transport that would be available currently in the facility. Interview revealed nursing would be expected to contact the administrative nursing supervisor and the patient's physician. Interview revealed that earlier on 9-06-07 at a medical staff meeting the discussion of prohibiting the use of handcuffs as a restraint device and to consider additional chemical restraint to control behavior. Interview revealed only psychiatry physicians can order restraint at the facility. Interview revealed five of

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A 165	Continued From page 22 the psychiatry physicians were not in attendance at the medical staff meeting, including the physician who ordered the metal handcuffs for patient #10. Interview confirmed the physician ordering the metal handcuffs as a restraint did not order the restraints according to current facility policy.	A 165		
A 347	482.22(b) MEDICAL STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. The medical staff must be organized in a manner approved by the governing body. If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine. This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review and staff interview, the facility's medical	A 347		9/20/07

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staff failed to ensure the least restrictive restraint method was ordered to restrain 1 of 3 restrained patients (#10).

Findings include:

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struck at staff members - placed in NCI (non-crisis intervention) hold & transported to restraints at 0129." Review of nursing documentation on the RIPN revealed Ativan 2mg po (oral) given at 0110. Further review of documentation on the RIPN at 0145 revealed "Release of patient from restrictive intervention:...Patient released from restrictive intervention(s) at Date: 8-03-07 Time: 0145...Other (describe) Released for transfer to (acute medical facility name)..." Review of nursing progress notes at 0215 revealed "...Client handcuffed per EMS request for transport...Discussed with (administrative nurse) at RNO (Administrative nursing office). Order obtained per (physician's name) as client combative and EMS uncomfortable (with) unrestrained transport..." Review of physician's orders on 8-03-2007 at 0200 revealed a telephone order received by a facility Registered Nurse "Handcuffs for xport (transport) to (acute medical facility's name) via EMS"

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felt like it was warranted. I informed RN (administrative nurse supervisor's name) that I could not handcuff a patient without just cause, but if the doctor on duty made the order for metal handcuffs, then it could be done according to hospital policy. The unit nurse in charge called (physician's name) and he did give the order for the patient to be handcuffed while being transported in the ambulance. I placed the handcuffs on the patient and gave the nurse, who was going with the patient to the hospital, the key and instructed her to remove the cuffs when they arrived at the hospital and to return the cuffs to me when transportation picked her us and brought her back to (hospital's name).

Interview with the reporting police officer on 9-06-2007 at 0958 revealed when he arrived on the unit the patient was in 4-point leather restraints. Interview further confirmed the statement in the report that the patient was not combative when the officer arrived on the unit. Interview confirmed the officer had no cause for placing the patient in handcuffs for law enforcement purposes. Interview confirmed the EMS made the demand for the continued restraints for transport to the medical facility or they would not transport the patient. Interview revealed there were no other alternatives available to restrain the patient other than the metal handcuffs. Interview revealed there was an attempt to remove the leather restraints from the bed, but the restraints were attached to the bedframe. Interview revealed once the unit nurse received the verbal order the officer placed the handcuffs on the patient. Interview revealed the patient was cooperative while placing the handcuffs. Interview further revealed the patient verbalized understanding of the procedure when

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explained to the patient by the officer. Interview revealed he was the only officer on campus at the time and for safety reasons could not leave the campus. Interview revealed the officer gave the handcuff key to the nurse after a brief inservice on how to unlock the handcuffs once the patient arrived at the medical facility. Interview revealed the officer had received at least eight hours of training on the use of handcuffs in officer training. Interview revealed such injuries as radial nerve and blood vessel injury, loss of circulation to the hand, swelling of the wrist and skin tears or lacerations can easily occur if the pressure exerted by the handcuff on the wrist is not monitored. Interview further revealed the officer did not contact his supervisor prior to using the handcuffs as a non-law enforcement restraint device.

Interview with the physician ordering the handcuffs as a restraint on 9-06-2007 at 0930 revealed only psychiatry staff can order restraints. Interview revealed that the metal handcuffs was the only device available to transport the patient with restrained. Interview revealed the physician was aware the decision to restrain the patient was a demand of the emergency medical transport staff. Interview revealed the physician is not aware of any policy on how to handle a situation where a patient needs to be transported by restraints. Interview revealed the decision was made that the metal handcuffs with monitoring by facility nursing staff during the transport by EMS was the least restrictive method available.

Interview with the facility Clinical Director (administrative liason physician) on 9-06-2007 at 1500 revealed there was a brief meeting about three weeks ago regarding the use of handcuffs

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A 347	Continued From page 27 as a restraint. Interview revealed there were no minutes from the meeting and no specific date could be recalled. Interview revealed the decision was made to further detail in the current policy (effective 11-01-06) that handcuffs could not be utilized as a restraint device. Interview revealed the physician did not know of any other least restrictive alternatives other than chemical restraint or a manual hold by staff during transport that would be available currently in the facility. Interview revealed nursing would be expected to contact the administrative nursing supervisor and the patient's physician. Interview revealed that earlier in the day of the interview at a medical staff meeting the discussion of prohibiting the use of handcuffs as a restraint device and to consider additional chemical restraint to control behavior. Interview revealed only psychiatry physicians can order restraint at the facility. Interview revealed five of the psychiatry physicians were not in attendance at the medical staff meeting, to include the physician who ordered the metal handcuffs for patient #10. Interview confirmed the physician ordering the metal handcuffs as a restraint did not order the restraints according to current facility policy.	A 347		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	A 385		9/20/07

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A 385	Continued From page 28 This CONDITION is not met as evidenced by: Based on policy and procedure review, hospital documents, observations during tour, review of hospital documents, closed medical record review and staff interviews the nursing staff failed to provide an organized nursing service by failing to: A) initiate appropriate emergency measures for 2 of 2 unresponsive patients during a medical emergency (#6,#9); B) follow physician's orders for 2 of 10 sampled closed medical records(#6, #9); C) update the patient's care plan related to elopement risk for 2 of 6 patients that attempted to elope/escape (#21, 17); and, D) date multidose medication vials (MDV) when opening the MDV prior to administering the first dose to patients on 2 of 3 nursing units observed during tour. Findings include: A) The facility's nursing staff failed to initiate appropriate emergency measures to 2 of 2 unresponsive patients during a medical emergency. (#6, #9) ~ cross refer to 482.23 (b) (3) RN Supervision of Nursing Care Tag A0395 B) The facility's nursing staff failed to follow physician orders for 2 of 10 sampled closed medical records.(#6, #9) ~ cross refer to 482.23 (b) (3) RN Supervision of Nursing Care Tag A0395 C) The facility's nursing staff failed to update the patient's care plan related to elopement risk for 2 of 6 patients that attempted to elope/escape (#21, 17)	A 385		

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A 385	Continued From page 29 ~ cross refer to 482.23 (b) (4) Nursing Care Plan Tag A0396 D) The facility's nursing staff failed to date multidose medication vials when opening the MDV prior to administering the first dose to patients on 2 of 3 nursing units observed during tour ~ cross refer to 482.23 (c) Administration of Drugs Tag A0404	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on policy and procedure review, hospital documents, closed medical record review and staff interviews the nursing staff failed: A) to initiate emergency measures for 2 of 2 sampled unresponsive patients (#6,#9); and B) to follow physician orders for 2 of 10 sampled closed medical records(#6, #9) The findings include: A) to initiate emergency measures for 2 of 2 sampled unresponsive patients (#6,#9); A)1. Review of the policy "Code Blue" effective 01/15/2001 revealed "Standard: Nursing Service employees shall respond immediately and utilize every resource to preserve life during a medical	A 395		9/20/07

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A 395	Continued From page 30 crisis." Review of the policy "Emergencies, Medical, Patients Code Blue Procedures" effective 11/01/2003 revealed "Purpose to provide appropriate and timely care/intervention in a life threatening medical emergency ...nursing...are trained and competent in basic life support for cardiopulmonary resuscitation, emergencies in which there is sudden cessation of circulation/respiration, or the potential for sudden cessation of circulation/respiration. Medical Emergencies may include, but are not limited to injuries, illnesses originating on any of the treatment units, or other incidents requiring the services of personnel other than the staff in the unit where the incident occurs. Medical Emergency Protocol: When an emergency exists, prior to arrival of a Physician of Physician Extender on the scene, trained nursing personnel will immediately initiate MD (medical doctor) verbal orders and the following measures are necessary to sustain life and/or to provide maximum comfort to the patient: 1. Provide an unobstructed airway,2. Check profuse external bleeding by direct pressure, applying pressure at pressure points, 3. Immobilize suspected fractures, 4. Monitor vital signs status, 5.Administer O2 (oxygen) at 6L/min (liters per min)., 6. Perform a venipuncture to establish an intravenous route for administration of (0.9% NACL) Sodium Chloride at keep-open rate...The first RN (registered nurse) on the scene ensures protocol measures are initiated. Review of the hospital document Code Blue Data dated 01/28/2007 for patient #6 revealed "Time Code Blue Called: 08:59AM ... Ending Time: 09:20AM."	A 395		

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A 395	Continued From page 31 Review of the hospital document "------ (name of hospital) Hospital Resuscitation Event Record dated 01/28/2007 for patient # 6 revealed "Time Event recognized: 0850 AM ..Time patient received Oxygen was at 0910 AM (patient was administered 4 liters of oxygen twenty minutes after the code blue was called and 18 minutes after the physician assistant wrote the order. The EMS and not the nursing staff administered the oxygen). Review of the "Code Blue Audit Tool" dated 01/30/2007 for patient # 6 revealed the nurse documented "Time oxygen started, and dose-0910 4/liters." Further review revealed "No documentation of oxygen delivery by --?. No time doc (documented) for time nurse responded, no doc of time of 1st, 2nd set of vital signs and no documentation of bleeding and injuries." Review of the Job description of a Registered Nurse not dated revealed "Recognize life-threatening situations and take appropriate action according to policy...Administer CPR (cardio-pulmonary-resuscitation)...and /or other emergency treatments to patients as needed." Medical record review revealed patient #6, a 45 year old male, was admitted on 01/23/2007 to the psychiatric hospital with diagnoses of paranoid schizophrenia, cocaine abuse and hypertension. Record review revealed a physician's order dated 01/28/2007 at 0852 "O2 2L/M by nose now." Record review of physician assistant's progress note dated 01/28/2007 at 0802 revealed "called to the pt (patient). Pt not responsive. B/P (blood pressure) 80/40..Called the name not responding to any order... Imp: (impression) hypotensive (low	A 395		

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blood pressure), not responding. Plan: IVF (intravenous fluids)125 cc (cubic centimeters).. O2 by NL (nasal liter) at 2L/min..keep legs elevated." Record review of physician's note dated 01/28/2007 at 0900 revealed " Code Blue Called-found pt slumped in chair-moved pt to floor .. 02 sat 94, unresponsive, pupils constricted and gaze directed to top of head. Flacid." Review of the primary nurse's progress notes documented at 0930 revealed "Called pt for meds (medications) did not answer or get up, called pt several times. Pt #---(medical record number) came to cart and stated "I think there's something wrong" Writer and ------(another nurse) checked pt, v/s (vital signs) were taken- B/P 90/52 (average blood pressure is 110/70) P(pulse) 48 (average pulse is 72) R(respirations) 30 (average respirations are 16-20), minimal response to stimuli or verbal command.. EMS (emergency medical system) arrived at 0906 IV had been started...placed on monitor, placed on stretcher, O2 started @ 5 L/min po (per mouth) transported to------ (acute hospital)." Record review of nurse's progress notes (who accompanied patient #6 to the acute hospital) dated 01/28/2007 at 0920 revealed "VS: B/P 108/78 P 44 (very low pulse) R 26 02 Sat 94% (while on 5 liters of O2). Respirations labored (difficulty with breathing), abdomen distended and tender to touch. Record review revealed patient #6 was transferred to an acute hospital with hypotension and sinus bradycardia (slow heart rate) and had a pacemaker (to regulate the heart rate) placed in the acute hospital.

Interview on 09/06/2007 at 1000 with the physician assistant revealed "I ordered oxygen and the patient's legs to be elevated at 0852 because of the low blood pressure. The patient

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was unresponsive and hypotensive." Interview revealed nursing should always apply oxygen to a patient during a medical emergency as the oxygen is used to prevent further deterioration of a patient's medical emergency. Further interview revealed the oxygen was not applied until 18 minutes after the order was written and twenty minutes after the patient was found unresponsive.

Interview on 09/06/2007 at 1400 with the assistant director of nursing revealed " During orientation the nurses are taught CPR (cardio-pulmonary-resuscitation). Our medical emergency policy states nurses are to apply oxygen during a medical emergency." Further interview revealed the supervisor could not give a reason why the nursing staff failed to apply oxygen to patient #6 during the medical emergency. Interview revealed "A patient with a low blood pressure and pulse should always have oxygen applied. The nursing staff should have administered oxygen immediately to patient #6. Twenty minutes is too long to wait before applying oxygen to an unresponsive patient."

Interview on 09/06/2007 at 1300 at with the primary care nurse revealed "I found the patient with a pulse of 48. A pulse of 48 is "really scary." I called the doctors stat (immediately) and called a 911 code. The patient was slumped in a chair, I moved him to the floor. The patient was unresponsive, his mouth was drooping and he was pale. The blood pressure was low. I didn't know the physician assistant had ordered oxygen so we did not apply the oxygen. I should have applied oxygen immediately because of the low pulse and blood pressure. I was an ACLS (advanced certified life support) nurse. I should have known better, I knew something was wrong

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with the patient, he was unresponsive. The oxygen was applied at 0910 by the emergency service system when they arrived. The physician assistant spoke to me after the code. He was upset that we had not administered the oxygen during the code".

Interview on 09/06/2007 at 1500 with the nurse supervisor revealed "We have been having problems with the way the nursing staff respond to medical emergencies. Most of the nurses have a psychiatric background and not an acute hospital background. During a medical emergency they always look for a "behavioral" reason for the cause of a patient becoming unresponsive. The nurses usually do not look for a physical reason, they do not do finger sticks to see if the blood sugars are abnormal or look for a physical reason causing the abnormal vital signs. A nurse should always apply oxygen when they find a patient unresponsive." Further interview revealed the nurses had failed to follow the medical emergency policy to administer oxygen. Interview further revealed, "It is a nursing standard of practice to apply oxygen immediately during a medical emergency."

Interview on 09/07/2007 at 1100 with the performance improvement nurse revealed, "When I did the audit of the code on 01/28/2007 I realized there were numerous problems. The nursing staff failed to follow the policy. The nursing staff failed to apply the oxygen. The documentation revealed the oxygen was not applied for 20 minutes after the patient was found unresponsive. The nursing staff failed to document who applied the oxygen on the code blue sheet, when they assess the patient's vital signs and if they assessed for bleeding and

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injuries." Further interview revealed the medical emergency policy had six nursing action steps the nurses are to perform. Interview revealed nursing had failed to follow the six steps (nursing performed three of the six steps).

A) 2. Review of the policy Clinical Care Plan: Screening of Referrals for Admission, Denial & Transfer of Patients with Medical Needs beyond Scope of (facility name) effective 10/16/06 revealed "Purpose: To establish policy and procedures governing the admission of patients to (facility name), ...transfer of patients denied admission due to medical needs beyond the scope of (facility name)." Further review of the policy revealed "Definitions: Emergency Medical Condition: a medical condition with acute symptoms ...so severe that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual in serious jeopardy; serious impairment to any bodily functions; serious dysfunction to any bodily organ or part ...Stabilize: to provide medical or psychiatric treatment necessary and available to assure that no significant worsening of the emergency medical or psychiatric condition is likely to result from, or occur during, the transfer." Further review revealed "Medical Screening Examination: ...H. When a patient first presents to the admissions office, initial vital signs shall be taken by admissions office staff and documented on the evaluation for admission form."

Review of the policy "Emergencies, Medical, Patients Code Blue Procedures" effective 11/01/2003 revealed "Purpose to provide appropriate and timely care/intervention in a life threatening medical emergency ...nursing...are trained and competent in basic life support for

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cardiopulmonary resuscitation in which there is sudden cessation of circulation/respiration, or the potential for sudden cessation of circulation/respiration ...Medical Emergencies may include, but are not limited to injuries, illnesses originating on any of the treatment units, or other incidents requiring the services of personnel other than the staff in the unit where the incident occurs. Medical Emergency Protocol: When an emergency exists, prior to arrival of a Physician of Physician Extender on the scene, trained nursing personnel will immediately initiate MD (medical doctor) verbal orders and the following measures are necessary to sustain life and/or to provide maximum comfort to the patient: 1. Provide an unobstructed airway, ...4. Monitor vital signs status, 5. Administer O2 (oxygen) at 6L/min (liters per min), 6. Perform a venipuncture to establish an intravenous route for administration of (0.9% NACL) Sodium Chloride at keep-open rate...The first RN (registered nurse) on the scene ensures protocol measures are initiated."

Review of a HCT II (health care technician II) job description revealed "Direct patient care duties...2. Observe, report and document any changes in behavior or physical changes in patients and reports to RN. 3. Recognizes life threatening situations and takes immediate action according to established policies. 4. Account for patient's presence, condition, and safety at least hourly and document according to established policy."

Review of the hospital Code Blue log from January 2007 - September 2007 failed to reveal a entry for a Code Blue called on 1/28/2007 at 2220 hours. Further review failed to reveal a

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completed Code Blue Data sheet by the hospital PI (performance improvement) staff.

Medical record review revealed patient #9, a 14 year old male transferred from an acute care hospital emergency department on IMH (involuntary mental health) papers to (facility name) hospital on 1/28/2007 at 2220. Record review revealed the patient arrived via law enforcement personnel. Record review revealed the patient "was combative and received po (by mouth) Ativan (anti-anxiety drug) ...2 milligrams of IM (intramuscular) Ativan and 5 milligrams of IM Haldol (antipsycotic drug)" at the referring acute care emergency department. Further review revealed that the patient was "unresponsive" with "decreased breathing." Record review revealed the patient was transferred to an acute care emergency department for further treatment and stabilization for "diagnosis (physical): non responding, decreased breathing." Record review of an HCT II treatment team progress note dated 1/28/2007 at 2220 hours revealed "unable to get vs (vital signs) from pt (patient). Pt was given medicines before coming to (facility name) and unresponsive- hard to wake up." Further review revealed a physician note dated 1/28/2007 at 2250 hours "...not able to be aroused or offer any information at all" [30 minutes after presentation to facility]. Further review revealed one set of vital signs dated 1/28/2007 at 2314 hours "T (temperature) 97.1, P (pulse) 69, R (respiration) 14, B/P (Blood Pressure) 101/55" [54 minutes after patient arrival]. Further review of a physician note dated 1/28/2007 at 2320 revealed "...Somnolent. Labored breathing [breathing produced or performed with difficulty]. Unresponsive" [one hour after presentation to facility]. Further review revealed a PA (physician

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assistant) note on 1/28/2007 at 2322 hours [62 minutes after presentation to facility] "Unresponsive, decreased breathing....CNS (central nervous system): Not responding to verbal stimuli ...Imp: (impression) Pt (patient) unresponsive, decreased breathing...Plan: Transfer pt to ER (emergency room) at (facility name). O2 (oxygen) NC (nasal cannula) at 2L/min (Liters per minute)." Record review failed to reveal the initiation of a Code Blue, notification of an RN by the HCT II, initiation of oxygen or IV (intravenous) therapy, continuous monitoring of vital signs or reassessment by a RN. Further record review failed to reveal a completed (facility name) resuscitation event record utilized when code blues are initiated.

Interview on 09/07/2007 at 1400 with the interim director of nursing revealed "the admissions unit is not staffed by an RN. A HCT II obtains vital signs, checks the paperwork, scans (body search for contraband) the patient, and notifies the physician of the patient arrival." Further interview revealed "patient's are not assessed by a RN until the decision has been made by the psychiatrist to admit the patient. A RN then assesses the patient when they arrive on the assigned unit." Further interview revealed in the event of a medical emergency "the HCT is to call a code." Further interview revealed "HCT's are taught the check, call, care method." Interview revealed "I can not say that proper [code blue] procedures were followed from the documentation." Further interview confirmed "The HCT should have called a code."

B) to follow physician orders for 2 of 10 sampled closed medical records(#6, #9)

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B)1. Review of the Licensed Practical Nurse job description, no date, reealed"Transcribe/implement physicians' orders according to nursing policy."

Medical record review revealed patient #6 , a 45 year old male, was readmitted on 02/06/2007 to the psychiatric hospital with a diagnosis of status post placement of a pacemaker. Record review of the discharge summary from the acute care hospital dated 02/02/07 stated "Discharge instructions: he is instructed to drink plenty of fluid....." Record review revealed an admission physician's order dated 02/06/2007 at 1410 "Push po (per mouth) fluids 12 oz (ounces) Q (every)2 hrs (hours)-hydration. Strict I & O (intake and output). Monitor hydration." Record review of the intake and output records failed to reveal documentation the nursing staff gave patient 12 oz of fluids every 2 hours and failed to reveal monitoring of patient #6's intake/output for 02/06-16/2007 (the form had no documentation). Further record review failed to reveal documentation of patient's hydration status. Interview on 09/06/2007 at 1200 with the registered nurse revealed nursing staffs are to follow physician orders. Further interview revealed there had been problems with the HCT (health care technicians) failing to monitor the intake and output of patient's fluids. Interview revealed "nursing staff had failed to follow the physicians' orders."
B) 2. Review of a HCT II (health care technician II) job description revealed "Direct patient care duties...2. Observe, report and document any changes in behavior or physical changes in patients and reports to RN. 3. Recognizes life threatening situations and takes immediate action according to established policies. 4. Account for

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A 395	Continued From page 40 patient's presence, condition, and safety at least hourly and document according to established policy...11. Assist Nurse, PA, or MD (medical doctor) with treatments, physicals, etc." Medical record review revealed patient #9, a 14 year old male transferred from an acute care hospital emergency department on IMH (involuntary mental health) papers to (facility name) hospital on 1/28/2007 at 2220. Record review revealed the patient arrived via law enforcement personnel. Record review revealed the patient was transferred to an acute care emergency department for further treatment and stabilization for "diagnosis (physical): non responding, decreased breathing." Further review revealed a PA (physician assistant) note on 1/28/2007 at 2322 hours [62 minutes after presentation to facility] "Unresponsive, decreased breathing....CNS (central nervous system): Not responding to verbal stimuli ...Imp: (impression) Pt (patient) unresponsive, decreased breathing...Plan: Transfer pt to ER (emergency room) at (facility name). O2 (oxygen) NC (nasal cannula) at 2L/min (Liters per minute)." Record review failed to reveal the initiation of oxygen by a RN or HCT II. Interview on 09/07/2007 at 1400 with the interim director of nursing revealed "I can not say that proper (code blue) procedures (applying oxygen) were followed from the documentation."	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.	A 396		9/20/07

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This STANDARD is not met as evidenced by:
Based on facility policy review, open and closed medical record review and staff and physician interviews, the facility's nursing staff failed to update the patient's care plan related to elopement risk for 2 of 6 patients that attempted to elope/escape (#21, 17).

The findings include:

Review on 9-06-2007 of the facility policy "Nursing Process" effective 5-15-2006 revealed "Comprehensive Nursing Assessment...11.c. Review of the Nursing Care Plan/Comprehensive Treatment Plan shall take place at the time of reassessment and changes made if relevant...12. ...Patient problems shall be entered into the chart by placing the problem statement on the tentative problem list...At the time of Treatment Team the treatment problems should be moved to the master problem list as appropriate."

1) Review of a closed medical record on 09/06/2007 revealed a 14 year old female, Patient #21, was admitted on 05/08/2007 with attention-deficit disorder, paranoia and bi-polar personality. Review of the nurse's documentation on 07/15/2007 at 1425 revealed "we all went to church. Pt (patient) was fine on the way over to church. ... we started walking back. (Patient #17 and 21) started walking in the middle of the street. Pt was asked several time to get on the sidewalk. Pt refused and continue to walk in the street. ...Pt started walking a little faster. ...Both patients started to run....was running down the hill toward the street. ...Pt was escorted back to the building.

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Pt then tried to run out the door and was placed in a NCI (North Carolina Intervention) hold for 3 minutes". Review of the nurses' documentation for 07/15/2007 at 2215 and 2245 revealed the patient remained on close observation (1:1 staff observation within arms length of the patient) for the remainder of the day. Review of the nurses' notes documented 07/16/2007 at 0617, 0725, 1515, 1615, 2145 and 2330 revealed the patient remained on close observation. Review of the record revealed the patient remained on close observation precautions until 07/18/2007 at 1145.

Review of the multi-disciplinary treatment plan for Patient #21 dated 07/26/2007, 11 days after Patient #21's attempted escape, revealed "Section 9. Treatment Plan Tracking Sheet ...Is the patient an escape risk?" The box was checked "No".

Interview with nursing administrative staff on 9/07/2007 at 1410 revealed nursing staff can identify tentative problems for consideration at treatment team on the "Tentative Problem List". Interview confirmed nursing did not address the patient's escape attempts on the "Tentative Problem List". Interview further confirmed nursing should have identified the escape attempts on the "Tentative Problem List" so a consideration for a master problem and identification of an escape risk would be considered. Interview confirmed nursing did not follow facility policy for identifying priorities listed in the nursing care plan.

Interview with facility psychiatry staff involved in the care of patient #21 on 9/07/2007 at 1220 revealed the patient was an escape risk. Interview revealed problems were not necessarily identified

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on the priority list but were documented in the progress notes. Interview confirmed the treatment plan reflected the patient was not an escape risk.

2) Open medical record review for patient #17 on 09/06/2007 revealed a 14 year old female admitted to the facility on 02-05-2007 with bipolar disorder and moderate mental retardation. Review of physician documentation on the "Initial Psychiatric Assessment" dictated 2-11-2007 revealed "Reason for admission: Chief complaint as per patient, "Running into traffic trying to kill myself". Further review of the "Initial Psychiatric Assessment" revealed "...Pt was discharged to a level III group home where she lasted only three hours. She ran away from group home...Patient continues to be very oppositional and defiant...ran into road and also tried to throw herself into the fire in the backyard where her adoptive father was burning the leaves..." Review of "Tentative Problem List" revealed on 2-05-2007 the following problems identified as priorities "Ineffective individual coping, High risk for injury: seizure activity, Needs immunization review, Potential ineffective airway clearance, Alteration in elimination: constipation, and Risk for falls". Further review of "Tentative Problem List" revealed on 2-13-2007 the problem "Placement problems/need more structured and therapeutic environment". Review of the "Prioritized Problem List" revealed on 2-13-2007 the following priority problems identified "Mood lability AEB (as evidenced by) attempting self harm and History of cognitive limitations (with) immature behaviors and poor coping skills, leading to difficulty in sustaining structured placement". Review of the "Tentative Problem List" revealed on 2-18-2007 the problem "Urinary Retention" identified, on

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3-05-2007 the problem "Alteration in comfort r/t (related to) menstrual cramps" identified, on 3-12-2007 the problem "Alteration in comfort r/t headache" identified, on 3-20-2007 the problem "Alteration in elimination urine retention" identified, and on 4-05-2007 the problem "Pain as evidenced by c/o (complaint of) right jaw & elbow pain" identified. Review of nursing documentation on 4-12-2007 at 1800 revealed "P# (priority number) Escape attempt - Pt (patient) attempted to climb over fence, stated "I'm running away from this f***** place" 1:1 ineffective...Pt remains uncooperative, threatening to run away...Instructed pt on dangers of running away..." Review of physician's orders on 4-13-2007 at 0730 revealed a telephone order "placed on escape precautions until evaluated by primary doctor - Target symptoms/justification - escape attempted". Review of nursing documentation on 7-15-2007 at 1440 revealed "...After leaving church, pt was walking in middle of street...began to walk faster (with) peer. Then pt began to run...down the hill into side of main highway...pt was escorted off the side of highway back up the hill, behavior began to escalate kicking and hitting at staff, pt placed in NCI hold (manual hold restraint)...pt placed in CO 1:1 (constant observation 1 staff to 1 patient)..." Review of "Tentative Problem List" revealed no additional problems identified from the 4-05-2007 problem "Pain as evidenced by c/o right jaw & elbow pain" through 7-18-2007 where a problem was identified "Alteration in comfort due to tooth pain". Review of "Prioritized Problem List" revealed no additional problems identified since the two problems identified on 2-13-2007 "Mood lability..." and "History of cognitive limitations...". Review of Section 9 of the treatment plan for 5-15-2007 revealed "Is the patient an escape

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A 396	Continued From page 45 risk? ('X' in box beside No)" Review of Section 9 of the treatment plan for 8-07-2007 revealed "Is the patient an escape risk? ('X' in box beside No)" Interview with facility psychiatry staff involved in the care of patient #17 on 9-06-2007 at 0935 revealed the patient was an attention seeker and would run from staff in order to be noticed. Interview revealed problems were not necessarily identified on the priority list but were documented in the progress notes. Interview confirmed the treatment plan reflected the patient was not an escape risk. Interview with nursing administrative staff on 9-06-2007 at 1050 revealed nursing staff can identify tentative problems for consideration at treatment team on the "Tentative Problem List". Interview confirmed nursing did not address the patient's escape attempts on the "Tentative Problem List". Interview further confirmed nursing should have identified the escape attempts on the "Tentative Problem List" so a consideration for a master problem and identification of an escape risk would be considered. Interview confirmed nursing did not follow facility policy for identifying priorities listed in the nursing care plan.	A 396		
A 464	482.24(c)(2)(iii) CONTENT OF RECORD - CONSULTS All records must document results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.	A 464		9/20/07

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A 464	Continued From page 46 This STANDARD is not met as evidenced by: Based on medical record review and staff interview, facility staff failed to document transfer information for 1 of 6 patients transfered to another facility (#10). Findings include: Closed record review for patient #10 revealed a 29 year old male presented to the psychiatric facility on 8-02-2007 at 2200 for evaluation and treatment of alcohol dependence. Review revealed the patient was transferred to an acute medical facility on 8-03-2007 at 0215 for treatment of symptoms related to acute deliruim tremens onset. Review revealed the patient was transferred back to the psychiatric facility on 8-04-2007 at 1200. Further review of progress notes by a facility social worker on 8-06-2007 at 1000 revealed "Pt seen today for initial contact...Contact made to access at (county) LME (Local Management Entities - or local mental health providers) or substance abuse referral..." Further review of progress notes on 8-08-2007 at 1430 by nursing staff revealed "Patient transferred to (substance abuse treatment facility)..." Review of progress notes on 8-08-2007 at 2150 by nursing staff revealed "Patient is a rapid return..." Further review of nursing progress notes on 8-09-2007 at 0115 revealed "...29 y/o (year old) WM (white male) readmitted U2-3East (clinical area) as rapid return. Was d/c'd (discharged) earlier today to (substance abuse treatment center) but denied admission for unknown reason..." Review revealed the patient was discharged home on 8-10-2007 at 1300.	A 464		

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A 464	Continued From page 47 Interview with social worker staff on 9-05-2007 at 1155 revealed the initial referral to the substance abuse faciity was completed by the interviewee's office. Interview revealed the facility had the authorization of the receiving facility to send the patient to the substance abuse facility on 8-08-2007. Interview revealed these conversations were documented on a referral form provided by the interviewee to the social worker assigned to the patient's unit. Interview revealed the receiving facility had made some changes to their intake process over the last four to six weeks and there had been some similar issues with other transfers to that particular facility. Interview further revealed that once the patient got to the receiving facility, the patient was denied admission related to some internal communication issues with the receiving facility. Interview further revealed any initial contacts, as well as subsequent contacts made by the facility's social worker staff with the receiving facility should be documented on the referral form. Interview confirmed the referral form was not included in the patient's medical record. Interview further confirmed the referral form should have been placed on the patient's medical record by the patient's assigned social worker. Interview confirmed there was no other documentation available on the medical record as to communications made between the transferring facility and receiving facility.	A 464		
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.	A 505		9/20/07

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This STANDARD is not met as evidenced by:
Based on policy and procedure review, observation and staff interviews the pharmacy department failed to ensure expired drugs were not available for patient use for 2 of 3 nursing units observed during tour.

The findings include:

Review of the policy "Multiple Dose Vials" effective 10/02/2002 revealed "A pharmacist will monitor for proper dating of punctured Tuberculin Skin Test (PPD) vials or any other product which must be used within a specific time frame as part of his/her monthly nursing station and treatment room inspections."

Review of the "Pharmacy Monthly Inspection Checklist" dated 08/29/2007 at 0915 and signed by the pharmacist revealed the section that stated "Are all refrigerated drugs in date? and Are multidose vials labeled correctly and in date with accordance with pharmacy policy, "Multidose Vials"? Further review of the checklist revealed the pharmacist had placed a check under the yes column for the above questions."

Observation during a tour on 09/04/2007 at 1400 of the U2 second floor medication room refrigerator revealed an open vial of PPD with the date of 08/11/2007 written on the box. Observation of the label on the vial stated to discard 30 days after opening the vial. Further observation revealed two opened vials of Lantus insulin not dated, one opened vial of Humulog insulin not dated, one opened vial of Humulin 30/70 insulin not dated, two opened vials of Regular insulin not dated, one opened vial of Humulin N insulin not dated and one opened vial

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A 505	Continued From page 49 of Humulog insulin not dated. Interview on 09/06/2007 at 1630 with the pharmacist revealed "I should have done a better job of checking the medication refrigerator. I am suppose to check the medications inside the refrigerator. I did not check the drugs. I just checked on the checklist that they were in date. The medications should have been discarded." Observation during a tour on 09/04/2007 at 1500 of the psychiatric medical infirmary unit refrigerator revealed an open vial of PPD with the date of 07/24/05 written on the box. Observation of the label on the vial stated to discard 30 days after opening the vial. Further observation revealed one opened vial of Humulin R insulin was not dated. Interview on 09/04/2007 at 1500 with the nurse manager revealed the medications were expired and should be discarded.	A 505		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and staff interviews the hospital failed to ensure supplies, sutures and equipment were not expired and available for patient use for 2 of 3 sampled patient units (1 and	A 724		9/20/07

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A 724	Continued From page 50 2 treatment rooms of the U2 building). The findings include: 1. Observation during a tour of the treatment room on the second floor of the U2 building on 09/06/2007 at 1400 revealed ten expired boxes of sutures. Three of the suture boxes were dated 01/2007 and the other seven boxes did not have an expiration date (per the manufacturer all sutures made before 1998 without an expiration date are expired). Further observation revealed two undated emergency obstetrical kits. Observation revealed each kit was covered with a brown film and a light cover of dust. Observation revealed 14 culture tubes with the expiration date of 04/20/07. Further observation revealed an opened, undated half empty bottle of Cidex (disinfectant) with an outer label that revealed "discard after the bottle has been opened 14 days." Interview on 09/04/2007 at 1500 with the nurse supervisor revealed "all the above supplies have been here longer than I have and I have been here 12 years." Interview revealed the above supplies were expired and should have been removed and unavailable for patient use. 2. Observation during a tour of the psychiatric medical unit treatment room on the first floor of the U2 building on 09/04/2007 at 1500 revealed an intravenous tray with two transparent dressings used to cover intravenous sites. Further observation of the outside of the dressing revealed "contents sterile if not opened-single use only". Observation revealed one of the dressings had been cut in half (the tray contained two cut pieces of dressings).	A 724		

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A 724	Continued From page 51 Interview on 09/04/2007 at 1530 with the registered nurse who was on her way to start an intravenous revealed "We always cut the dressing in half and use both halves on separate occasions to cover the intravenous site. This has been the standard practice here." Interview on 09/04/2007 at 1540 with the nurse manager revealed "the nurses should discard the second half of the dressing when they chose to use only the one half of the dressing to cover the IV site. The second half of the dressing would not be sterile for future use to cover an IV site." NC00039959	A 724		